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September 8, 2020

House Insurance Committee
via email to Committee Clerk Sergio Cavazos at Sergio.Cavazos_HC@house.texas.gov

Chairman Lucio,

The Texas Association of Health Plans (TAHP) is the statewide trade association representing health insurers, health maintenance organizations, and other related health care entities operating in Texas. Our members provide health and supplemental benefits to Texans through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid.

We are writing to provide information in response to your RFI regarding the implementation of Senate Bill 1264, which prohibits "surprise" balance billing and creates an "arbitration" system to settle balance bills. Our members sincerely appreciate your leadership and hard work last session in developing a bipartisan legislative solution to address Texas' out-of-network surprise medical billing crisis. We share your commitment to fixing this problem and strongly support policies that will protect consumers without adding to overall costs in the health care system.

It is clear that a ban on surprise billing protects Texas patients. According to a recent Texas Department of Insurance (TDI) report, SB 1264 has resulted in a 95% reduction in the number of Texans submitting consumer complaints of providers surprise billing them.[1] As a result of your work last session, Texas went from one of the worst states in the country for surprise medical bills to having one of the strongest protections in the country for Texas patients — an absolute prohibition on surprise medical billing for care in emergencies and other situations when Texans receive care from a provider they did not choose. The law applies to the roughly 20% of Texans who have health coverage through a health plan with provider networks regulated by TDI or through the state employee or teacher retirement systems.

Surprise billing reflects a market failure: patients usually do not choose their emergency or facility-based physicians, so the flow of patients to these physicians depends on the hospital in which they practice — not the prices they charge or whether they join insurer networks. Physician specialties that use this market failure to bill out of network have substantially higher charges compared to other doctors (see following chart).

[1] https://www.tdi.texas.gov/reports/documents/SB1264-preliminary-report.pdf

## Physicians that Can Surprise Bill Have Very High Charges

Ratio of Charges to Medicare Allowed Amounts by Physician Type, 2016

| | 20th Percentile | Median | 80th Percentile |
|---|---|---|---|
| Anesthesiologists | 2.25 | 5.51 | 11.08 |
| Emergency Medicine | 2.79 | 4.65 | 7.50 |
| Diagnostic Radiology | 2.64 | 4.02 | 8.03 |
| Pathology | 2.25 | 3.43 | 5.10 |
| | | | |
| All Other Specialists | 1.46 | 2.27 | 4.01 |
| All Primary Care | 1.39 | 2.03 | 3.54 |

Source: Analysis of Medicare Provider Utilization of Payment Data: Physician and Other Supplier Public Use File, 2016

USC Schaeffer BROOKINGS

While a ban protects insured patients from the initial surprise bill, data now shows that payment dispute processes tied to billed charges increase health care costs and drive up premiums. TAHP believes further study and work is needed to improve Texas' dispute resolution process so the solution both protects patients from surprise bills and reins in health care costs and premiums. TAHP recommends further review and discussion of potential improvements in a number of areas:

1. Payment dispute resolution processes should not rely on billed charges
2. Payment dispute resolution processes and use of the associated database should not increase administrative burden and costs
3. Surprise billing rules should provide clear guidance
4. Provider licensing agencies should adopt regulations and enforce the surprise billing prohibition

**Payment Dispute Resolution Processes Should not Rely on Billed Charges**

During the legislative process, TAHP supported SB 1264's strong consumer protections but consistently opposed the use of billed charges in determining a rate in out-of-network billing disputes (new section 1467.083 of the Insurance Code directs arbitrators to consider the 80th percentile of billed charges). Since last year's legislative session, new research and data — including an analysis by the Congressional Budget Office — have further revealed that the use of billed charges in any payment dispute process will inappropriately drive up health care costs and insurance premiums.[2]

[2] https://thehill.com/policy/healthcare/462833-cbo-rival-fix-for-surprise-medical-bills-costs-double-digit-billions

In Texas, there is already evidence that our new arbitration process's reliance on the 80th percentile of billed charges are causing the same problems as it is resulting in payouts that are substantially higher than average negotiated rates in Texas and the U.S. TAHP believes including the 80th percentile of billed charges as a primary factor for consideration by arbitrators is skewing outcomes toward higher amounts and adding significant costs to the health care system. It also further incentivizes an out-of-network model that drives up the cost of insurance. The vast majority of arbitration requests have come from large emergency physician groups; in fact, about 85% of dispute resolution requests are coming from only three physician "staffing and billing companies."[3][4] This reflects the rise of private equity-backed management and billing companies that are rapidly consolidating emergency physician and anesthesiology practices in Texas, artificially inflating billed charges and significantly driving up health care costs.[5]

**The problem with billed charges (and why it's worse in Texas)**
Providers' billed charges are unlimited, unregulated, and typically have no relation to real costs or to what providers actually accept as full payment. According to Christen Linke Young of the USC-Brookings Schaeffer Initiative for Health Policy, "Billed charges are effectively just made up."[6] When providers can be virtually assured they will receive their full billed charge by not contracting with health plans, they have no incentive to join networks. This restricts health plans' ability to manage costs through contracting with providers, allows providers to drive up premiums and out-of-pocket costs for consumers by self-determining and inflating charges, and encourages contracted providers to leave networks. Texas already has the most expensive billed charges for emergency care in the country. In the past four years alone, the 80th percentile of billed charges in Texas has almost doubled (from 700% to 1200%) and is significantly higher than in the rest of the U.S. In fact, the U.S. 80th percentile of billed charges is almost the same as Texas' 50th percentile. Therefore, a law that results in Texas doctors being reimbursed based on the 80th percentile of charges could **increase payments by almost 500% of the average negotiated rate**, significantly increasing out-of-pocket costs and premiums for Texans.[7]

The cost of surprise bills is a small portion of all health care spending, but policies that address surprise bills can have important consequences for the health care system because they affect negotiations between insurers and providers. Insurers negotiate lower in-network payments to providers by promising increased patient volume and by declining to cover (or providing reduced benefits for) out-of-network care, but those tools are largely ineffective for the providers that generate the majority of surprise bills. Certain types of providers can charge higher amounts by declining to join a network — a strategy that is most effective for providers whose services are

[3] https://www.tdi.texas.gov/reports/documents/SB1264-preliminary-report.pdf
[4] https://cdn.ymaws.com/www.tahp.org/resource/collection/166932DB-AB31-4C45-881D-24FD8A95D2BA/IDR_Webinar_for_TAHP.pdf
[5] https://www.propublica.org/article/how-rich-investors-not-doctors-profit-from-marking-up-er-bills
[6] https://www.houstonchronicle.com/business/article/It-cost-what-Medical-pricing-shrouded-in-13781730.php
[7] FAIR Health data: Data copyright © 2018, FAIR Health, Inc. All rights reserved. Used by permission. Copying, use and further distribution prohibited.

not directly chosen by patients, such as anesthesiologists, radiologists, pathologists, assistant surgeons, and emergency physicians.

There are payment dispute resolution solutions that protect patients from surprise billing while reducing premiums and health care costs. Recent activity around surprise billing at the federal level has revealed a general consensus that the inclusion of billed charges for consideration in any dispute resolution process would increase premiums. In fact, all current federal surprise billing proposals **prohibit the use of billed charges as any type of standard**.[8] TAHP strongly recommends the Legislature consider revising SB 1264 so that the arbitration process does not require consideration of billed charges.

**Payment dispute resolution processes should not increase administrative burden and costs**
SB 1264 required TDI to set up two separate payment dispute processes (arbitration for non-facility providers and mediation for facilities), making it administratively complex. Prior to SB 1264, all eligible providers used the mediation process. Compared to that process, which was in place through 2019, less disputes are now being resolved through the informal settlement process and more are going through the formal dispute process, so the new arbitration process is more administratively burdensome and expensive than mediation. According to TDI's numbers, the percentage of disputes resolved during the informal settlement process has significantly dropped. Since the arbitration process became available in January, only 70% of arbitration cases settled in the initial 30-day settlement period, while over 95% of disputes settled during the informal settlement period as part of the mediation process in place prior to SB 1264. Additionally, arbitration is expensive, with arbitrator fees ranging from $270-$5000,[9] and administratively complex, with very short timeframes for parties to submit information. TDI expects over 30,000 cases to go through a formal arbitration process this year.[10][11]

The use of a billed charges benchmarking database also makes this process unnecessarily complex. Some of the complexity is the result of a baseball style arbitration process that relies heavily on billed charges. TAHP strongly urges the Legislature to reconsider the provision in SB 1264 that requires TDI to choose an organization to maintain a benchmarking database for arbitrators regarding the 80th percentile of billed charges and the 50th percentile of contract rates for non-facility providers. First, such a database is not necessary if billed charges are not considered. Second, there seems to be no entity that currently meets the requirements of this statute, and TDI did not provide for an open bidding process. Instead, TDI selected FAIR Health's databases and ignored questions from TAHP and other stakeholders about an apparent conflict of interest and the methodologies used in creating the databases. TAHP strongly encourages the committee to review these open questions as well as the need for such an

[8] https://www.commonwealthfund.org/blog/2020/update-surprise-billing-legislation-new-bills-contain-key-differences
[9] https://www.tdi.texas.gov/medical-billing/mediator-arbitrator-list.html
[10] https://www.tdi.texas.gov/reports/documents/SB1264-preliminary-report.pdf
[11] https://cdn.ymaws.com/www.tahp.org/resource/collection/166932DB-AB31-4C45-881D-24FD8A95D2BA/IDR_Webinar_for_TAHP.pdf

administratively complex process. Moving all dispute resolution back to the mediation process would eliminate the billed charges problem, the administrative complexity of arbitration, and the database requirements.

**Surprise Billing Rules Should Provide Clear Guidance**
There is confusion regarding the applicability of TDI's "usual and customary charge" and "hold harmless" rules following adoption of SB 1264, and clear guidance is needed. TDI has also created new confusion for health plans and consumers regarding whether SB 1264 applies to out-of-state plans that are not regulated by TDI. TDI's independent dispute resolution portal initially allowed health plans to "reject" arbitration requests for claims under out-of-state plans as ineligible, but TDI removed that option with no notice or explanation. TDI adopted two sets of rules to implement SB 1264 but did not address these issues. Health plans, administrators, and providers need clear regulatory guidance in order to comply with SB 1264, so TDI should be required to draft rules clarifying its applicability.

**Provider Licensing Boards Should Adopt Rules and Enforce the Ban on Surprise Billing**
None of the state provider regulatory agencies responsible for enforcing SB 1264 have adopted rules to implement the balance billing prohibition. We recommend the Legislature direct all agencies that have responsibilities over health care providers and that are subject to SB 1264 to adopt rules implementing the law's balance billing prohibition. We also recommend the Legislature review how these agencies are enforcing that prohibition to protect consumers.

**Closing**
TAHP enthusiastically supported SB 1264 during the 2019 legislative process, and we are excited for the benefits Texans have already seen because of these new consumer protections. However, TAHP strongly encourages the committee to address the arbitration process, including the overreliance on billed charges and how administratively burdensome the process has become.

Thank you for your leadership on this important issue. TAHP and our members appreciate your receptiveness to the information and perspectives we provide in this letter. As you continue to explore legislative options to address the cost of health care in Texas, we stand ready to work with you to help solve this serious problem.

Sincerely,

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